DPHHS-SLTC CFC/PAS 200
(New 7/14)

State of Montana
Department of Public Health and Human Services

Person Centered Planning Form

Name: _____ **Plan Date:** _____
Medicaid ID: _____ **DOB:** _____
Provider Agency: _____ **Plan Facilitator:** _____

Goals: Things I would like to work on or achieve this year. My dreams, plans and goals.

Schedule preferences: 3 most important things for personal care attendants to know when working with me (routines, scheduling preferences, things that make me happy/upset):

Strengths: What am I good at? What are my talents?

Personal Care Attendant skills needed: What skills would I like my personal care attendant to have?

Services: What kind of help would make me successful in reaching my goals?

Back-up plan: Who will assist me if my personal care attendant isn't available? What will my plan look like in this situation?

Support: Who do I call when I need help?

Please initial to acknowledge (only on intake):

I have received and understand my rights and responsibilities and those of my Plan Facilitator: _____

I have received the Conflict Resolution and Grievance Procedures information: _____

I have received an Advocacy Resource Guide: _____

I have received my CFC/PAS Handbook. _____

Member/Personal Rep. _____ **Date:** _____

Plan Facilitator: _____ **Date:** _____

Provider Agency: _____ **Date:** _____